Client name _____

Client Information Form

For Debra Haverson Psychotherapy Associates – Madison, NJ

Name of client _____ Date of Birth _____

IF CLIENT IS A MINOR, then please provide adult name(s) _____
Relationship to child: _____ Are you the legal guardian?_____

Address _____

Home phone _____ Cell _____ Work _____ Select: first call H C O

Email address (optional) _____

Emergency Contact info: _____

Insurance information if applicable (and copy of insurance card front and back):

Company _____ Name of Member/Insured: _____
Billing address: _____ Relationship to client: _____
_____ Member ID: _____
Claims phone: _____ Group # if applicable: _____
Member's Employer: _____
(or school if applicable)

If Member/Insured *has a different address* and/or phone then information above, please provide that here:

Name _____ Date of Birth _____
Address _____
Home phone _____ Cell _____ Work _____ Select: first call H C O

Current status (student, occupation, retired, etc.)

_____

Primary Care Physician and town where office is located

_____

Client name _____

Reason for seeking therapy:

Family History:

(Do not answer first two questions if you are filling out the form for children/teens under 18.)

Briefly describe current family structure. Include whether client is in a personal relationship (for example, dating, living together, married)?

If you are an adult not living with parents, who is in your family of origin? Also list those who are deceased and give ages for those still alive.

Who do you/client consider in your support network?

Do any immediate family members have now or in the past had a psychiatric illness? If yes, please state relationship to yourself/client, description or diagnosis, and when this occurred.

Did any close family member or friend die prematurely (accident, illness, etc.)?

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Please fill out the quick reference table below. We will discuss the specifics in more detail.

	YES/NO **If no, leave other columns blank.)**	**When Past/current**	**Brief description**	**Therapist's notes (leave this blank)**
Has the client gone to therapy before?				
Does the client take any prescription medications for any physical, emotional or cognitive issue?			List meds:	
Has the client ever had a serious head injury? Any loss of consciousness?				
Was client ever hospitalized? If so, state reason.				
Any inpatient, outpatient or never-treated psychiatric history?				
Does the client drink caffeinated coffee or tea or energy drinks?				
Does the client drink alcohol?				
Use of other drugs? (past or present)				
Does client smoke?				
Does client (now or in past) engage in a sport or other physical activity?				
Any car, bike, motorcycle or other accidents where some injury occurred?				
Other: such as legal/criminal issues, history of physical fighting or domestic violence (including as victim)?				

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SUPPLEMENTAL Client Information Form FOR CHILDREN/TEENS UNDER 18

Child's school (and the town) and grade for upcoming or current school year:

_____

Are there difficulties related to school? _____

If so, circle all appropriate:

*Learning difficulties ADD/ADHD Dislikes school Social difficulties Other:*_____

Do you want therapist to communicate with school? _____

If so, you will be asked to fill out consent forms to allow the school and the therapist to share information.

Are there difficulties related to family members: _____

Are parents together? _____

Who lives in the home? _____

What other family members (siblings, parents, animals, others) live elsewhere? Describe briefly their relationship, ages, and whether the child sees regularly:

When did difficulties begin? _____ We will discuss specifics.

Does the youth want to attend therapy or is it strictly the parent's or school's idea?

_____

Any notable pre-natal events or difficulties during birth or early childhood?

_____